COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 13, 2010

Rex Redden, Administrator
Idaho Falls Group Home #1 Bellin
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #1 Bellin, Provider #13G024

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #1 Bellin, which was conducted on August 6, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or

other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 25, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informational Letter #2007-02. State Informational Letter #2007-02 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/ICFMR/tabid/431/Default.aspx

This request must be received by August 25, 2010. If a request for informal dispute resolution is received after August 25, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srp
Enclosures

Aug 24 10 04:50p

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G024	A. BUILDING _____ B. WING _____	08/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 BELLIN	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Leader Barbara Dern, QMRP Common abbreviations/symbols used in this report are: HRC - Human Rights Committee ITTP - Interdisciplinary Treatment Team Plan MAR - Medication Administration Record QMRP - Qualified Mental Retardation Professional	W 000		
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a relevant and comprehensive vocational assessment was obtained for 4 of 4 individuals (Individuals #1 - #4) who were of working age and for whom such assessments were required. Without a comprehensive assessment, the facility would be unable to assist each individual with their vocational training needs, through the development of objectives designed to optimize their abilities. The findings include: 1. Individual #3's 8/27/09 ITTP documented a 35 year old female diagnosed with profound mental retardation.	W 225	W 225 1. All individuals have the potential to be affected by this practice. The vocational assessment form will be revised to incorporate a section for work interests, recommendations for improving existing or emerging skills needed for employment, or present and future employment options. All vocational assessments will then be reviewed and updated using the new form. 2. The QMRP will update the vocational assessment form to include a section for work interests, recommendations for improving existing or emerging skills needed for employment, or present and future employment options. The vocational assessments will be reviewed annually at each individuals treatment plan meeting and will be revised as needed. If there are significant changes in the individuals vocational functioning level the vocational assessment will be updated throughout the year. 3. Target date for completion will be October 6, 2010.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Andrea Ellis — Admin — 8/24/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Aug 24 10 04:50p

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W 225	Continued From page 1 Her record included a Vocational Assessment, dated 6/8/10, that was scored using a rating system (full assistance, light touch, verbal/shadowing, minimal gesture, and no help). The assessments including various skills and scoring consisted of marking the appropriate rating of each skill in one of three categories (has skills, emerging skills, and no skills). Attached to the assessment was a page titled "Narrative Summary of Needs." The assessments did not include information related to work interests, recommendations for improving existing or emerging skills needed for employment, or present and future employment options. 2. Individual #4's 4/30/09 ITTP documented a 24 year old male diagnosed with profound mental retardation and cerebral paly. His record included a Vocational Assessment, dated 6/9/10, that was scored using a rating system (full assistance, light touch, verbal/shadowing, minimal gesture, and no help). The assessments including various skills and scoring consisted of marking the appropriate rating of each skill in one of three categories (has skills, emerging skills, and no skills). Attached to the assessment was a page titled "Narrative Summary of Needs." The assessments did not include information related to work interests, recommendations for improving existing or emerging skills needed for employment, or present and future employment options. 3. Individual #2's 4/30/10 ITTP stated she was a	W 225		

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W 225	Continued From page 2 36 year old female whose diagnoses included profound mental retardation and cerebral palsy. Individual #2's Vocational Assessment, dated 6/3/10, was scored using a rating system (full assistance, light touch, verbal/shadowing, minimal gesture, and no help). The assessment including various skills and scoring consisted of marking the appropriate rating of each skill in one of three categories (has skills, emerging skills, and no skills). Attached to the assessment was a Narrative Summary of Needs. However, the assessments did not include information related to work interests or present and future employment options. 4. Individual #1's 10/29/09 ITTP stated she was a 32 year old female whose diagnoses included profound mental retardation, autism, scoliosis, and bilateral cataracts. Individual #2's Vocational Assessment, dated 6/3/10, was scored using a rating system (full assistance, light touch, verbal/shadowing, minimal gesture, and no help). The assessment including various skills and scoring consisted of marking the appropriate rating of each skill in one of three categories (has skills, emerging skills, and no skills). Attached to the assessment was a Narrative Summary of Needs. However, the assessments did not include information related to work interests or present and future employment options. During an interview on 8/5/10 from 2:45 - 4:30 p.m. the QMRP stated the Vocational Assessments for Individuals #1 - #4 did not	W 225		

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W 225	Continued From page 3 contain sufficient information and needed to be updated. The facility failed to ensure Individual #1 - #4's vocational assessments contained specific and comprehensive information.	W 225		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 3 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #2's 4/30/10 ITTP stated she was a 36 year old female whose diagnoses included profound mental retardation and cerebral palsy. She relied on a power wheelchair, which she was able to control, for mobility. A Plan Sheet for Inappropriate Driving, revised 1/2010, stated if Individual #2 drove into an object or person, staff were to back her chair up and drive Individual #2 to her bedroom. The facility's Behavior Modification Program	W 262	W 262 1. All individuals have the potential to be affected by this practice. HRC approval will be obtained for the use of restrictive interventions. 2. Anytime a behavior intervention is implemented, the Treatment Team will review the intervention and compare it to the behavior modification policy in order to determine if the intervention is a restrictive procedure. The Treatment Team will make the determination and sign an addendum to the treatment plan stating which level it falls under according to the behavior modification policy. If the intervention is found to be restrictive, HRC approval will be obtained by the QMRP. All restrictive interventions will be reviewed by the HRC every six months or as needed throughout the year. 3. Target date for completion will be October 6, 2010.	

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W 262	Continued From page 4 Guidelines, revised 5/24/10, defined redirection to a neutral area as "Assisting an individual to relocate to a different area of the home. This will be used when the individual will not independently move to a different location to relax or calm down after they have engaged in an undesirable behavior." The Behavior Modification Program Guidelines stated relocation to a neutral area required written consent from the individual's guardian and approval from the HRC. Individual #2's record did not contain approval from the HRC. When asked during an interview on 8/5/10 from 2:45 - 4:30, the QMRP stated she had not received HRC approval for Individual #2's Inappropriate Driving program. The facility failed to ensure HRC approval was obtained prior to the use of restrictive interventions for Individual #2.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the parent/guardian for 1 of 3 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of an	W 263		

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W 263	Continued From page 5 individual's rights through prior consent for restrictive interventions. The findings include: 1. Individual #2's 4/30/10 ITTP stated she was a 36 year old female whose diagnoses included profound mental retardation and cerebral palsy. She relied on a power wheelchair, which she was able to control, for mobility. A Plan Sheet for Inappropriate Driving, revised 1/2010, stated if Individual #2 drove into an object or person, staff were to back her chair up and drive Individual #2 to her bedroom. The facility's Behavior Modification Program Guidelines, revised 5/24/10, defined redirection to a neutral area as "Assisting an individual to relocate to a different area of the home. This will be used when the individual will not independently move to a different location to relax or calm down after they have engaged in an undesirable behavior." The Behavior Modification Program Guidelines stated relocation to a neutral area required written consent from the individual's guardian and approval from the HRC. Individual #2's record did not contain written informed consent from the guardian. When asked during an interview on 8/5/10 from 2:45 - 4:30, the QMRP stated she had not obtained guardian consent for Individual #2's Inappropriate Driving program. The facility failed to ensure guardian consent was obtained prior to the use of restrictive interventions for Individual #2.	W 263	W 263 1. All Individuals have the potential to be affected by this practice. Written informed consent from the guardian will be obtained for all restrictive interventions. 2. Anytime a behavior intervention is implemented, the Treatment Team will review the intervention and compare it to the behavior modification policy in order to determine if the intervention is a restrictive procedure. The Treatment Team will make the determination and sign an addendum to the treatment plan stating which level it falls under according to the behavior modification policy. If the intervention is found to be restrictive, guardian consent will be obtained by the QMRP. Guardian consent will continue to be obtained annually for all on-going interventions and as needed when new restrictive interventions are implemented throughout the year. 3. Target date for completion will be October 6, 2010.	
W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369		

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W 369	Continued From page 6 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure medications were administered without error for 3 of 5 individuals (Individuals #1, #5, and #6) observed to take medications. This resulted in the potential for individuals not to receive the full dose of medications. The findings include: 1. Individual #1's 7/19/10 Physician's Orders stated she was a 32 year old female. She received a multivitamin (a supplemental drug), Solia (an hormonal drug), Senokot (a laxative drug) 8.6 mg every other morning, Nasonex (an antihistamine drug) 1 puff in each nostril twice daily, Astelin (an antihistamine drug) 137 mcg 2 puffs in each nostril twice daily, Synthroid (an hormonal drug) 100 mcg each morning, and Paxil (an antidepressant drug) 10 mg each morning. During an observation on 8/3/10 from 5:45 - 8:20 a.m., staff were noted to crush Individual #1's multivitamin, Solia, Senokot, Synthroid, and Paxil pills. Staff then took a spoonful of applesauce out of a jar and placed the applesauce in the medication cup with the crushed pills, mixed the pills and applesauce, and used hand over hand assistance to help Individual #1 take the drugs. Individual #1 consumed the applesauce and pill mixture. When she finished, staff took the medication cup and went to throw the medication cup away. The Surveyor asked for the medication cup and noted it contained no less than 1.5 teaspoons of applesauce with visible pill	W 369	W 369 1. All individuals have the potential to be affected by this practice. The Home Supervisor and the Medical Coordinator will retrain all staff on how to accurately assist individuals with self administering medications. 2. The Medical Coordinator will conduct weekly medication observations to ensure that all individuals are being assisted with administering their medications appropriately and accurately. The Medical Coordinator will complete a medical observations checklist form during each observation. On-going training on how to accurately assist with administering all individuals medications will be completed during monthly staff meetings by the Home Supervisor and Medical Coordinator. The QMRP will attend weekly nurses meetings and review observation checklists that are completed by the Medical Coordinator to ensure on-going training is being completed. 3. Target date for completion will be October 6, 2010.	

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W 369	Continued From page 7 fragments. When asked during the observation, the staff assisting Individual #1 with her medication programs stated she should have placed the applesauce and pills in a larger container to make it easier to scrape out, and should have checked the container to ensure Individual #1 consumed all of her medications. The staff then scraped the remaining applesauce and pill fragments onto a spoon and used hand over hand assistance to help Individual #1 consume the remaining applesauce and pill fragments. When asked during an interview on 8/5/10 from 2:45 - 4:30 p.m., the Medical Coordinator stated staff should have placed the applesauce in a bowl, poured the crushed medications into the bowl, and allowed Individual #1 to consume her medications from the bowl. 2. Individual #5's 7/19/10 Physician's Orders stated she was a 24 year old female. She received Reglan (an antiemetics drug) 10 mg and Prevacid (an antiulcer drug) 30 mg each morning. During an observation on 8/3/10 from 5:45 - 8:20 a.m., staff were noted to crush Individual #5's pills. Staff then took a spoonful of applesauce out of a jar and placed the applesauce in small bowl, mixed the pills in the applesauce, and used hand over hand assistance to help Individual #5 take the drugs. Individual #5 consumed the applesauce and pill mixture. When she finished, staff took the bowl and went to place it in the sink. The Surveyor asked for the container and noted it contained no less than 1.5 teaspoons of applesauce with visible pill fragments.	W 369		

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W 369	Continued From page 8 When asked during the observation, the staff assisting Individual #5 with her medication programs she stated staff try to ensure all pill fragments have been consumed, but sometimes it is difficult. The staff stated, they get as much out as possible and rinse out the rest. The staff then used hand over hand assistance to help Individual #5 consume the remaining applesauce and pill fragments. When asked during an interview on 8/5/10 from 2:45 - 4:30 p.m., the Medical Coordinator stated staff should have ensured that all medications had been consumed prior to rinsing the bowl. 3. Individual #6's 7/19/10 Physician's Orders stated she was a 35 year old female. She received Baclofen (a skeletal muscle relaxant) 30 mg three times a day, lactulose (a laxative drug) 15 cc in the morning, Prevacid solutabs (an antacid drug) 30 mg two times a day, calcium carbonate (a supplemental drug) 500 mg three times a day, vitamin D (a supplemental drug) 400 units in the morning, phenobarbital suspension (an anticonvulsant drug) 60 mg (15 cc) in the morning, Benadryl (an antihistamine drug) 25 mg (10 cc) two times a day, multivitamin (a Suplena drug) in the morning, Carafate (an antiulcer drug) 10 cc four times a day, Sprintec (an hormonal drug) 1 in the morning. During an observation on 8/3/10 from 5:45 - 8:20 a.m., staff were noted to measure out Individual #6's Carafate, Benadryl, lactulose, and phenobarbital into medication cups. Staff read the MAR for the phenobarbital and measured 7.5 cc of phenobarbital then handed the bottle to the Surveyor. The pharmacy label stated Individual #6 was to receive 60 mg (15 cc) in the morning,	W 369		

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W 369	Continued From page 9 30 mg (7.5 cc) at 11:30, and 60 mg (15 cc) at night. During the observation, the staff assisting Individual #6 with her medication programs was asked about the discrepancy in dosage (i.e. 7.5 cc versus 15 cc). The staff stated she did not see the dose of 15 cc and had only seen the 7.5 cc instruction for 11:30 a.m. The staff then measured out the additional 7.5 cc of phenobarbital. When asked during an interview on 8/5/10 from 2:45 - 4:30 p.m., the Medical Coordinator stated staff should have seen the correct dose on the bottle and the MAR. The facility failed to ensure Individual #1's, #5's, and #6's medications were administered without error.	W 369		
W 370	483.460(k)(3) DRUG ADMINISTRATION The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure medications were administered only by licensed personnel in accordance with state law for 1 of 5 individuals (Individual #3) who were observed taking medications. This resulted in medication being administered contrary to State law. The findings include: 1. Individual #3's 7/19/10 Physician's Orders documented a 35 year old female diagnosed with	W 370		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G024	A. BUILDING _____ B. WING _____	08/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 BELLIN	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
W 370	Continued From page 10 profound mental retardation. Her Physician's Orders documented she was to receive 1 tablespoon of fiber laxative in 8 ounces of water a day. During an observation on 8/2/10 from 3:00 - 4:00 p.m., a staff was noted to prepare the fiber laxative in the water and place it on the dining room table. However, during snack, a second staff was noted to mix the fiber laxative into water and assist Individual #3 to take the mixture using hand over hand assistance. When asked, the staff who was assisting Individual #3 stated she was not medication certified. Idaho Administrative Code 23.01.01.490, dated 2010, defined Unlicensed Assistive Personnel (UAP) as unlicensed personnel employed to perform nursing care services under the direction and supervision of licensed nurses. Additionally, Idaho Administrative Code 23.01.01.490.05 states "after completion of a Board-approved training program, unlicensed assistive personnel in care settings may assist patients who cannot independently self administer medications." When asked, during an interview on 8/6/10 from 9:00 - 9:15 a.m., the Medical Coordinator and QMRP both stated that they were unaware that the staff assisting with the administration of the fiber laxative was not medication certified. Both stated a medication certified staff should have been assisting Individual #3. The facility failed to ensure medications were only administered by licensed personnel.	W 370	W 370 1. All Individuals have the potential to be affected by this practice. The Home Supervisor and the Medical Coordinator will retrain all staff on who can assist individuals with self administering medications. 2. The Medical Coordinator will conduct weekly medication observations to ensure that all individuals are being assisted with administering their medications appropriately and accurately and only by licensed personnel. The Medical Coordinator will complete a medical observations checklist form during each observation. On-going training on how to accurately assist with administering all individuals medications will be completed during monthly staff meetings by the Home Supervisor and Medical Coordinator. The QMRP will attend weekly nurses meetings and review observation checklists that are completed by the Medical Coordinator to ensure on-going training is being completed. 3. Target date for completion will be October 6, 2010.	
W 382	483.460(l)(2) DRUG STORAGE AND	W 382		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 382	Continued From page 11 RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions. This failure directly impacted 1 of 8 individuals (Individuals #3), and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include: 1. Individual #3's 7/19/10 Physician's Orders documented a 25 year old female diagnosed with profound mental retardation. Her Physician's Orders documented she was to receive 1 tablespoon of fiber laxative in 8 ounces of water a day. An observation was conducted on 8/2/10 from 3:00 - 4:00 p.m. During that time, staff were noted to unlock the medication cart and place a medication cup of fiber laxative on the dining room table. The medication cup was left on the table, unattended, from 3:15 - 3:35 p.m. During that time, other individuals and staff were observed to be in and out of the area preparing snacks. When asked, during an interview on 8/6/10 from 9:00 - 9:15 a.m., the Medical Coordinator and QMRP both stated all drugs should be locked	W 382	W 382 1. All individuals have the potential to be affected by this practice. The Home Supervisor and the Medical Coordinator will retrain all staff on keeping drugs and biologicals locked except when being prepared for administration. 2. The Medical Coordinator will conduct weekly medication observations to ensure that all drugs and biologicals are locked except when being prepared for administration. The Medical Coordinator will complete a medical observations checklist form during each observation. On-going training on how to accurately store all drugs and biologicals will be completed during monthly staff meetings by the Home Supervisor and Medical Coordinator. The QMRP will attend weekly nurses meetings and review observation checklists that are completed by the Medical Coordinator to ensure on-going training is being completed. 3. Target date for completion will be October 6, 2010.	

Aug 24 10 04:56p

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W 382	Continued From page 12 unless being administered. The facility failed to ensure all drugs were locked except when being administered.	W 382		

Aug 24 10 04:57p

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MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 Refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM196 Refer to W263	
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W225.	MM724	MM724 Refer to W 225	
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753	MM753 Refer to W 382	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin. — (X6) DATE: 8/24/10

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MM755	Continued From page 1	MM755		
MM755	16.03.11.270.02(f)(ii)(a) Resident unable to Self-Administrate If the resident is not capable of self-administration of medications under staff supervision, this fact must be documented in the resident's assessment. Such residents cannot be accepted by facilities unless a licensed nurse is on duty to administer and record such medications. This Rule is not met as evidenced by: Refer to W370.	MM755	MM755 Refer to W 370	
MM759	16.03.11.27.02(f)(v) Medication Error Any medication error must be reported immediately to the resident's attending physician and documented in the resident's record. This Rule is not met as evidenced by: Refer to W369.	MM759	MM759 Refer to W 369	